DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF

STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:	2. STATE
SPA #03-15	Kansas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.252

7. FEDERAL BUDGET IMPACT:
a. FFY 2003 $ 50,000
b. FFY 2004 $ 790,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A
Pages 3, 4, 16, 21, 22, 23, 24, 25 & 25c
Outline, Page ii

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.16-A, Pages 1 thru 5
Attachment 4.19-A
Pages 3, 4, 16, 21, 22, 23, 24, 25 & 25c
Outline, Page ii

10. SUBJECT OF AMENDMENT:
Outlier Payment Percentage

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED:
Janet Schalansky is the Governor's Designee

12. SIGNATURE OF STATE AGENCY OFFICIAL:
//Janet Schalansky – signature//

13. TYPED NAME:
Janet Schalansky

14. TITLE:
Secretary of Social & Rehabilitation Services

15. DATE SUBMITTED:
June 9, 2003

16. RETURN TO:
Janet Schalansky, Secretary
Social & Rehabilitation Services
Docking State Office Building
915 SW Harrison, Room 651S
Topeka, KS 66612-2210

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
June 9, 2003

18. DATE APPROVED:
June 28, 2004

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL - 1 2003

20. SIGNATURE OF REGIONAL OFFICIAL:
Dennis G Smith

21. TYPED NAME:
Dennis G. Smith

22. TITLE:
Director, CMSO

23. REMARKS:

Methods and Standards for Establishing Payment Rates – Inpatient Hospital Care

1.0 Continued

s. "General hospital inpatient beds" means the number of beds as reported by the general hospital on the hospital and hospital health care complex cost report form excluding those beds designated as skilled nursing facility or intermediate care facility beds. For hospitals not filing the hospital and hospital health care complex cost report form the number of beds shall be obtained from the provider application for participation in the Kansas Medicaid/Medikan Program form.

t. "Group reimbursement rate" means the dollar value assigned by the Department to each general hospital group for a diagnosis related group weight of one.

u. "Large Public Kansas Teaching Hospital" is a public hospital located within the State of Kansas with a minimum of 200 inpatient beds and a minimum of 100 interns and residents.

v. "Length of stay as an inpatient in a general hospital" means the number of days an individual remains for treatment as an inpatient in a general hospital from and including the day of admission, to and excluding the day of discharge.

w. "Low income utilization rate" means the sum of (1) the fraction expressed as a percentage, the numerator of which is the sum for a period of the total revenues paid by Medicaid to the hospital for patient services and the amount of the cash subsidies for patient services received directly from state and local governments, and the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and (2) a fraction expressed as a percentage, the numerator of which is the total amount of the hospital's charges for inpatient hospital services which are attributable to charity care in a period, less the portion of any cash subsidies (as referred to above in (1)) in the period reasonably attributable to inpatient hospital services, not including contractual allowances and discounts other than for indigent patients not eligible for Medicaid and the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period. Medicaid revenue shall include payment made to the hospital from managed care entities on behalf of Medicaid beneficiaries.

x. "Medicaid inpatient utilization rate" means a fraction expressed as a percentage, the numerator of which is the hospital's number of inpatient days attributable to patients who for such days were eligible for Medicaid in a period, and the denominator of which is the total number of the hospital's inpatient days in that period. The numerator shall include managed care patient days for Medicaid eligible beneficiaries.

y. "Metropolitan statistical area (MSA)" means a geographic area designated as such by the United States executive office of management and budget.

Methods and Standards for Establishing Payment Rates – Inpatient Hospital Care
2.4430 continued

Analysis

The relative weight of .6881 in this example means that this DRG is less expensive to treat than the average DRG (with a weight of 1.0000). In other words, it indicates this DRG costs 31.19% less in relation to average DRGs.

2.4440 Modification of Relative Weights for Low-Volume DRGs

If very few paid claims are available for a DRG, any one claim can have a significant effect on that DRG's relative weight, day outlier limit, cost outlier limit, and daily rate. A statistical methodology was used to determine the minimum sample size required to set a stable weight for each DRG, given the observed sample standard deviation. For DRG's lacking sufficient volume in the Kansas Medicaid/Medikan claims data base, the DRG weight was derived using an external data base, with preference given to DRG weight derived from populations expected to be similar to the Kansas Medicaid/Medikan population. Sources used were an average of four states all payer data from 1997 from Kansas, Colorado, Iowa, and Wisconsin, and HCFA Medicare weights where other alternatives were not sufficient.

Outlier thresholds and average length of stay statistics for DRG's with externally derived weights were set using the appropriate statistics from the same external source. For DRG's whose weights were derived from Federal Medicare weights, in which case published cost outlier thresholds are based on a substantially different formula than is used by Kansas Medicaid, a least-squares regression equation was used to estimate the outlier threshold, based on the DRG weight.

2.4450 Modification of Relative Weights for Selected DRG Pairs

In cases of DRG "pairs" – one DRG with complications and co-morbidity (CC's) and the other DRG without CC's – if the DRG without CC's was weighted higher than the DRG with CC's, the relative weights of both DRG's were replaced with the weighted average of the two relative weights.

2.4500 Group Payment Rates

The Kansas Department of Social and Rehabilitation Services determined group payment rates for the three general hospital groups discussed in section 2.3000. The group payment rates are used in conjunction with DRG relative weights and other components developed for the Kansas DRG reimbursement system to determine payment. An adjustment factor of –2.84% was applied to the group payment rates effective July 1, 2003 to offset the increase in the outlier payment percentage.

Methods and Standards for Establishing Payment Rates – Inpatient Hospital Care

2.5100 Identification of Outlier Claims.

Each claim that is eligible for an outlier payment, will be tested to determine whether it meets the cost and/or day outlier criteria. If the claim does not qualify as either a cost or a day outlier, the standard DRG payment will be made to the hospital, unless the claim falls under one of the categories discussed in subsections 2.5400 through 2.5720 and another method is used for computing payment.

2.5110 Test for Cost Outlier

The covered charges on the claim will be multiplied by the pre-established Medicaid cost to charge ratio for the hospital (subsection 2.4700) to estimate the cost of the claim. If the estimated cost is higher than the cost outlier limit established for the DRG which has been assigned to the claim, a cost outlier payment will be made to the hospital in addition to the standard DRG amount.

2.5120 Testing for Day Outlier

If the covered length of stay on the claim is higher than the day outlier limit established for the DRG that has been assigned to the claim, a day outlier payment will be made to the hospital in addition to the standard DRG amount.

2.5130 Example of Testing for Outlier

Data

Hospital Data:	Group Payment Rate	$ 2,836
	Cost to Charge Ratio	.78
Claim Data:	Covered Charges	$39,760
	Covered Length of Stay	50 days
DRG Data:	DRG Weight	4.2294
	Cost Outlier Limit	$32,899
	Day Outlier Limit	67 days
	Daily Rate	$ 503
	Adjustment Percentage	.75

Computation/Comparison

Testing for Cost Outlier

Estimated Cost of Claim	=	Covered Charges x Ratio	
	=	$39,760	x .78
	=	$31,013	
Compare With Cost Outlier Limited		$32,899	

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Section 2.5130 continued

Testing for Day Outlier:

Covered Length of Stay	50 days
Compare with Day Outlier Limit	67 days

Analysis

Cost Outlier: The estimated cost of the claim ($31,013) is less than the cost outlier limit ($32,899). Therefore, the claim is not a cost outlier.

Day Outlier: The covered length of stay on the claim (50 days) is less than the day outlier limit (67 days). Therefore, the claim is not a day outlier.

2.5200 Standard DRG Payment

Standard DRG amount will constitute the base payment for an inpatient discharge except in those situations where a partial payment may be made. Any outlier payment for the qualifying claims will be in addition to the standard DRG payment.

Standard DRG amount for a claim can be obtained by multiplying the relative weight of the DRG assigned to the claim, by the group payment rate assigned to the hospital.

Example of Standard DRG Payment Calculation:

Referring to the data in subsection 2.5130:
Standard DRG Payment = DRG Weight x Hospital Group Payment Rate

=	4.2294	x	$2,836
=	$11,995		

2.5300 Payment for Outlier Claims

If a covered general hospital inpatient stay is determined to be a cost or day outlier, the total reimbursement will consist of the standard DRG payment plus an additional amount for the outlier portion of the claim.

2.5310 Cost Outlier Payment

The payment for the cost outlier portion of a claim will be obtained by multiplying the difference between the estimated cost of the claim and the applicable cost outlier limit, by the DRG adjustment percentage. Cost outlier payment will be made for up to 360 inpatient days of stay, beyond which only day outlier payment will be made.

Methods and Standards for Establishing Payment Rates – Inpatient Hospital Care

2.5310 continued

Example of Computing Cost Outlier Payment:

Data

Hospital Data	:	Same as subsection 2.5130
Claim Data	:	Covered Charges...$45,980
DRG Data	:	Same as subsection 2.5130
Standard DRG Payment:		$11,995 (from subsection 2.5200)
Assumption	:	Not a day outlier

Computations

Estimated Cost	=	Covered Charges	x	Hospital Ration		
	=	$45,980	x	.78		
	=	$35,864				
Payment for Cost		Estimated		Cost Outlier	DRG Adj.	
Outlier Portion	=	(Cost	-	Limit)	x	Percentage
	=	($35,864	-	$32,899)	x	.75
	=	$ 2,224				
Total Payment	=	Std. DRG Pymt	+	Outlier Pymt.		
	=	$11,995	+	$2,224		
	=	$14,219				

2.5320 Day Outlier Payment

The payment for the day outlier portion will be obtained by multiplying the difference between the covered length of stay and the applicable day outlier limit, by the DRG daily rate and the DRG adjustment percentage.

Example of Day Outlier Payment Computation:

Data

Hospital Data	:	Same as subsection 2.5130
Claim Data	:	Covered Length of Stay.....73 days
DRG Data	:	Same as subsection 2.5130
Standard DRG Payment:		$11,995 (from subsection 2.5200)
Assumption	:	Not a cost outlier

Computations

Payment for		Covered		Day		DRG		DRG
Day Outlier	=	[Length	-	Outlier]	x	Daily	x	Adjustment
Portion		[of Stay		Limit]		Rate		Percentage
	=	(73	-	67)	x	$503	x	.75
	=	$2,264						

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Section 2.5320 continued

Total Claim Payment	=	Standard DRG Payment	+ Outlier Payment
	=	$11,995	+ $2,264
	=	$14,259	

2.5330 Simultaneous Cost and Day Outlier Payment

If a covered general hospital inpatient stay is determined to be both a cost outlier and a day outlier, the reimbursement will be the greater of the amounts computed for cost outlier and day outlier.

Example of Payment for Simultaneous Cost and Day Outlier:

Data

Total Claim Payment for Cost Outlier....$14,219 (subsection 2.5310)
Total Claim Payment for Day Outlier.....$14,259 (subsection 2.5320)

Analysis

The higher of the two amounts, $14,259, will be the reimbursement amount for the claim which meets both cost outlier and day outlier criteria.

2.5340 Pay No More Than Charges

After the determination of the payment, including any applicable outliers, hospitals shall be paid the lesser of the Medicaid allowed amount and their allowed charges. Allowed charges are determined based upon which revenue codes are allowed as covered services.

2.5400 Payment for Transfers

When a recipient is transferred during a covered general hospital inpatient stay from one hospital to another hospital, or to a psychiatric or rehabilitation wing of the same hospital, the reimbursement to all hospitals involved in the transfer(s) will be computed as follows.

2.5410 Transferring Hospital(s)

The reimbursement to each transferring general hospital shall be the DRG daily rate for each covered day of stay. Total payment to each transferring hospital shall be no greater than the standard DRG amount, except where the transferring hospital is eligible for outlier payments.

2.5420 Discharging Hospital

The discharging general hospital shall be reimbursed the standard DRG amount. If the claim qualifies as an outlier, the discharging hospital shall be eligible for an outlier payment based solely on the length of stay at the discharging hospital.

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2.5430 Transfer To or From a non DRG Hospital

If the transferring hospital or the discharging hospital is not a hospital reimbursed under the DRG system as identified in 2.1000, reimbursement to the non DRG hospital will be computed according to the methodology for non DRG hospitals.

2.5440 Example of Payment Determination in Transfers

The following situation will provide an illustration of the various payment methods used when a patient is transferred from one hospital to another. Although the situation may not be realistic with regard to the medical treatment provided, it shows all basic payment methods for patient transfers through a single example.

A patient is admitted to a state operated hospital (Hospital A), and after a stay of two days with $1,400 in billed charges, the patient is transferred to a general hospital (Hospital B). Hospital B has the patient for three days and the case is assigned DRG #186. Hospital B is in Group 2. The patient is then transferred to another general hospital (Hospital C) due to complications. The patient is discharged after six days from Hospital C, and is assigned DRG #186. Hospital C is in Group 1.

Payment to Hospital A: Since Hospital A is a state operated hospital, the payment will be determined using the methodology specified in the section on state operated hospitals.

Payment to Hospital B: Hospital B is a transferring general hospital, and will therefore be paid a DRG daily rate for each day of stay, with total payment limited by the standard DRG amount.

Data Used for this example:

DRG Daily Rate	$ 597
DRG Weight	.6515
Group 2 Rate	$2307

The transfer payment will be computed by multiplying the number of days times the DRG daily rate; i.e., 3 times $597, or $1,791. This amount will be compared against the standard DRG amount, and the lesser of the two shall be paid. The standard DRG amount is .6515 times $2,307, or $1,503. Therefore, Hospital B would be paid $1,503.

Payment to Hospital C: Hospital C is a discharging general hospital, and would therefore be paid the standard DRG amount plus any outlier payment, if applicable.

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2.6000 Settlements and Recoupments

There shall be no year end settlements under the DRG reimbursement system. However, some settlements and recoupments may occur because of Surveillance/Utilization Review or other reviews which determine that payments were in error.

3.0000 General Hospital Reimbursement for Inpatient Services Excluded from The DRG Reimbursement System

Reimbursement for heart, liver and bone marrow transplant services shall be excluded from the DRG payment system. Reimbursement for these transplants shall be based upon the lesser of reasonable costs or customary charges, contingent upon transplant surgery. Due to the unusual nature of these services, negotiated rates which pay no more than the DRG daily rate may be paid. For services provided prior to the transplant surgery, or if transplant surgery is not performed, reimbursement shall be made according to the DRG payment system.

4.0000 Reimbursement for Inpatient Services in State Operated Psychiatric and Large Public Kansas Teaching Hospitals

Reimbursement for inpatient services in state operated psychiatric hospitals shall be based upon the lesser of reasonable costs or customary charges for covered services rendered to eligible individuals. These costs shall include Medicare allowable costs, including but not limited to malpractice, capital, physician services, and education as allowed under federal law. Reimbursement for inpatient services in large public Kansas teaching hospitals shall be paid as a percentage of charges with a maximum of 100%. Payment rates shall be established based upon a review of the cost reports and the federal upper payment limit to insure that no more than 100% of charges is paid as well as no more than the federal upper payment limit is paid. A review of their cost report shall also be made to estimate reasonable cost. This would not include physician costs, but would include all other costs that were identified in the state operated psychiatric hospitals above. The minimum payment rate that would be made would be the lesser of the billed charges and 85% of the estimated reasonable cost. The specific rate for large public Kansas teaching hospitals will be negotiated with the provider(s) to comply with federal upper payment limits. The payment method described for large public Kansas teaching hospitals is effective with dates of service on and after 7/1/2003.

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